GIC RMT ENROLLMENT FORM (FORM-RMT)

Commonwealth of Massachusetts
Group Insurance Commission

REQUIRED

INSURED INFORMATION

Insured Information	GIC-ID (usually Soc. Sec. #) – –	Sex ☐ M ☐ F	Date of Birth / /	Agency/Division # (GIC use only) /
	Name – Last	First		MI
Address	Street	City	State	Zip
Contact Information	Home Phone ( ) / Cell Phone ( )	Email	Country *(if not USA)*	
Claim Number	Insured's Medicare Claim #	Spouse's Medicare Claim #		

Retirement Information	Name of Municipality or school district retired from	Will you receive a monthly pension from a public retirement system? ☐ Yes ☐ No	Date of Retirement / /

HEALTH AND BASIC LIFE

☐ **Basic Life Only** ☐ **Basic Life and Health**

MEDICARE PLAN – Select one if you and/or your spouse/covered dependents are enrolled in Medicare.

☐ Tufts Medicare Preferred (HMO)
☐ Harvard Pilgrim Medicare Enhance (Indemnity)
☐ Health New England Medicare Supplement Plus (Indemnity)
☐ Tufts Medicare Complement (Indemnity)
☐ UniCare State Indemnity Medicare Extension CIC: ☐ Yes ☐ No

Medicare Coverage Election
☐ Individual
☐ Individual and spouse
☐ Family

Check all that apply:
☐ Individual on Medicare
☐ Spouse on Medicare
☐ Dependent(s) on Medicare

NON-MEDICARE PLAN – Select one if you and/or your spouse/covered dependents are not enrolled in Medicare.

☐ Fallon Direct (HMO)
☐ Fallon Select (HMO)
☐ Harvard Pilgrim Independence (POS)
☐ Harvard Pilgrim Primary Choice (HMO)
☐ Health New England (HMO)
☐ NHP Prime–Neighborhood Health Plan (HMO)
☐ Tufts Health Plan Navigator (POS)
☐ Tufts Health Plan Spirit (HMO-type)
☐ UniCare State Indemnity/Basic CIC: ☐ Yes ☐ No
☐ UniCare Community Choice (PPO-type)
☐ UniCare/PLUS (PPO-type)

Non-Medicare Coverage Election
☐ Individual
☐ Family

SPOUSE/DEPENDENT INFORMATION *(See instructions on back)*

For Changes Only	LAST NAME	FIRST NAME	MI	SSN (REQUIRED)	DATE OF BIRTH	SEX	RELATIONSHIP
☐ Add ☐ Drop					/ /	☐ M ☐ F	
☐ Add ☐ Drop					/ /	☐ M ☐ F	
☐ Add ☐ Drop					/ /	☐ M ☐ F	
☐ Add ☐ Drop					/ /	☐ M ☐ F	

FORMER SPOUSE INFORMATION – If Listed Above

Date of Divorce: / /

Are you remarried? ☐ Yes ☐ No	Date of your remarriage: / /	Has your former spouse remarried? ☐ Yes ☐ No	Date of former spouse's remarriage: / /	
Address: Street		City	State	Zip

SIGNATURE REQUIRED

AUTHORIZATION – I have read the instructions on the reverse side of this form and direct my pension authority to deduct from my pension check the amount required for the coverage I have selected. I understand that my health insurance coverage elections are binding for the duration of the plan year and that I may only enroll in health insurance or change my coverage elections during the plan year if I experience a qualifying status change (examples include marriage, adoption/ birth of a child, death of a dependent, and involuntary loss of other coverage). I understand that the GIC must receive any required documentation within 60 days of the event.

Signature of Applicant: _____ Date: _____

CERTIFICATION OF RETIRING TEACHER'S INSURANCE COVERAGE (REQUIRED)

To be completed by Payroll/Insurance Coordinator at your Municipality/school district.

I certify that the above applicant is currently covered under our local life and/or health insurance program and will be covered until his/her retirement coverage begins the first day of the third month after the date of retirement. I will notify the Group Insurance Commission if coverage is interrupted before the retirement coverage begins.

Signature: _____ Date: _____

Please Print Name and Position: _____

For GIC Use Only	Entered	Verified	Political Subdivision

(See over for instructions)

GIC RMT ENROLLMENT FORM (FORM-RMT) INSTRUCTIONS

Use this form for enrolling in GIC benefits for the first time at retirement.

For an overview of your GIC health insurance benefit options, see the GIC Benefit Decision Guide mass.gov/gic/bdgs.

Deadlines and Required Documentation

- **Required documentation:** To add a spouse or dependent to coverage, documentation is required. Visit our website for the Required Documentation list: mass.gov/guides/gic-forms.
- If you and/or your spouse is **Medicare eligible**, the following documentation must accompany this form:
  - Photocopy of your Medicare Card (include a copy of spouse's card if applicable).
  - Photocopy of your latest 1099 or the Benefit Verification letter printed from Social Security's website stating how your monthly Part B premium is paid (e.g., you are being directly billed by Social Security or it is being deducted from your Social Security check). Include this same documentation for your spouse, if applicable.
- If you and/or your spouse are over age 65 and ***not eligible for Medicare***, the following must accompany this form:
  - Social Security Denial letter stating that you and/or your spouse are not eligible for Medicare Part A for free.

Your health insurance election includes basic life insurance.

Retiree and Spouse Coverage if Under and Over Age 65

If you (the retiree), your spouse or other covered dependent is younger than age 65, the person or people under age 65 will continue to be covered under a Non-Medicare plan until you and/or he/she becomes eligible for Medicare. Be sure to choose "individual" Non-Medicare coverage if only covering one Non-Medicare family member; select "family" Non-Medicare coverage if covering two or more Non-Medicare family members.

The following plans are available:

Non-Medicare Plan
Fallon Health Direct Care
Fallon Health Select Care
Harvard Pilgrim Independence Plan
Harvard Pilgrim Primary Choice Plan
Health New England
Neighborhood Health Plan
Tufts Health Plan Navigator
Tufts Health Plan Spirit
UniCare State Indemnity Plan/Basic
UniCare State Indemnity Plan/Community Choice
UniCare State Indemnity Plan/PLUS

Medicare Plan
Harvard Pilgrim Medicare Enhance
Health New England Medicare Supplement Plus
Tufts Health Plan Medicare Complement
Tufts Health Plan Medicare Preferred
UniCare State Indemnity Plan/Medicare Extension (OME)

If enrolling in one of GIC's Medicare Plans, you will be automatically enrolled in the GIC's SilverScript Medicare Part D prescription drug plan. After your enrollment is processed by the GIC, you will receive a mailing from SilverScript with information about the plan and advising you that you have the choice to opt out of the prescription drug plan. The opt-out letter is required by Medicare, but we do not recommend that you do so because **if you opt out of SilverScript, you will lose your GIC medical, prescription drug and behavioral health coverage**.

Form and Documentation Submission: Return completed form and documentation to the GIC, P.O. Box 8747, Boston, MA 02114